

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 4 - 0 0 2

2. STATE:

TENNESSEE

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 12, 2004

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 430.12(b)

7. FEDERAL BUDGET IMPACT:

a. FFY 2003/2004 \$ 0

b. FFY 2004/2005 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 7, page 89.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Section 7, page 89.

10. SUBJECT OF AMENDMENT:

General Provisions - State Governor's Review.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

J. D. Hickey

14. TITLE:

Deputy Commissioner

15. DATE SUBMITTED:

July 14, 2004

16. RETURN TO:

Tennessee Department of Finance
and Administration
Bureau of TennCare
729 Church Street
Nashville, Tennessee 37247-6501

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

July 14, 2004

18. DATE APPROVED:

08/09/04

19. EFFECTIVE DATE OF APPROVED MATERIAL:

07/12/04

20. SIGNATURE OF REGIONAL OFFICIAL:

Renard L. Murray

21. TYPED NAME:

Renard L. Murray, D.M.

22. TITLE:

Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

Revision: HCFA-PM-91-4
AUGUST 1991

(BPD)

OMB No. 0938-

State/Territory: TENNESSEE

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Center for Medicare and Medicaid Services with such documents.

X Not applicable. The Governor --

X Does not wish to review any plan material.

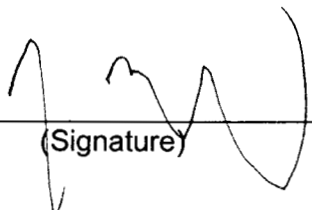
 Wishes to review only the plan materials specified in the enclosed document

I hereby certify that I am authorized to submit this plan on behalf of

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

(Designated Single State Agency)

Date: 7/14/2004



(Signature)
Deputy Commissioner

(Title)

D1035039

TN No. 2004-2

Supersedes

TN No. 2002-4

Approval Date 8/09/2004

Effective Date 7/12/2004